TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Grace Medical Center

Respondent Name
Twin City Fire Insurance Co

MFDR Tracking Number
M4-16-3088-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 10, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I disagree with the reimbursement on codes 29807, 29824, and 23430. I provided documentation that supports my appeal. Please review for determination on whether or not additional payment is due."

Amount in Dispute: $7,143.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 29807 and 23430 are J1 codes. Payment and complexity adjustment rules are found in the Hospital Outpatient Regulations and Notices section of the CMS website."

Response Submitted by: The Hartford, 300 S. State St., One Park Place, Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 5, 2016	Outpatient Hospital Services	$7,143.65	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 4097 – Paid per fee schedule. Charge adjusted because statute dictates allowance is greater than provider's charge
- 193 – Original payment decision is being maintained. This claim was processed properly the first time

The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided..." The applicable Medicare payment policy may be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPPS services which are:

1. **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
   To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.
2. **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum D1.
3. **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.
4. **Discounting** - Multiple surgical procedures furnished during the same operative session are discounted. The full amount is paid for the surgical procedure with the highest weight. Fifty percent is paid for any other surgical procedure(s) performed at the same time;
5. **Composite** - Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable fee pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The Requestor's DWC060 shows codes 29807and 29824 in dispute. These codes were denied with adjustment/reason code(s) 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and 243 – "Included/bundled within the value of another procedure performed." Review of the Status Indicator are "J1" for 29807 and "T" for 29824. 28 Texas Administrative Code §134.403 (d) states in pertinent part,

> For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…

Review of MLN (Medicare Learning Network) Matters MM9014, found at www.cms.hhs.gov, which states,

> *Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:*
>
> - *Major OPPS procedure codes (status indicators P, S, T, V);*
> - *Lower ranked comprehensive procedure codes (status indicator J1);*

Review of the rankings of the submitted codes with J1 status indicators (23430 and 29807) found at Addendum B of www.cms.hhs.gov/HosptialOutpatientPPS/, finds 23430 has the highest ranking and pursuant to the applicable Medicare payment rule, the carrier's denial of services being bundled is supported.

2. 28 Texas Administrative Code §134.403 (f) states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent;

The remaining services in dispute are reimbursed based on the following:

Submitted code	Status Indicator	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
23430	J1	5123	$4,969.26	$4,969.26 x 60% = $2,981.56	$2,981.56 x 0.8421 = $2,510.77	$4,969.26 x 40% = $1,987.70	$2,510.77 + $1,987.70 = $4,498.47	$4,498.47 x 200% = $8,996.94
							Total	$8,996.94

3. The maximum allowable reimbursement for the eligible service is $8,996.94. The carrier paid $8,996.94. No additional payment is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		July , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.